



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

JIMMY YOON, MD
PO BOX 741865
DALLAS, TX 75374

Respondent Name

DALLAS NATIONAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 20

MFDR Tracking Number

M4-11-3572-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: From Table of Disputed Services: "CARRIER IS REQUIRED TO PAY DD EXAMS" and from Position Statement: "AN ORIGINAL BILL AND A RECONSIDERATION WERE SUBMITTED, THE CURRENT RULES ALLOW REIMBURSEMENT."

Amount in Dispute: \$150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: A copy of dispute was sent to carrier on October 27, 2011 with no response to MFDR

Response Submitted by: NA

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 11, 2011	99456-WP-W5	\$150.00	\$150.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services effective March 1, 2008.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:
Explanation of benefits dated April 14, 2011
- W1 – Workers Compensation State Fee Schedule Adjustmen
 - Z710 – The charge for this procedure exceeds the fee schedule allowance

Issues

1. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to reimbursement?

Findings

1. The requestor billed the amount of \$650.00 for CPT code 99456-WP-W5 for Division ordered DD examination for Maximum Medical Improvement/Impairment Rating (MMI/IR). Review of the documentation supports that the doctor assigned MMI. Per 28 Texas Administrative Code §134.204(j)(3)(C), the Maximum Allowable Reimbursement (MAR) for MMI is \$350.00. Per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(I), the MAR for an IR using Diagnosis Related Estimates (DRE) Category II method on the lumbar (spinal region) is \$150.00. The combined MMI/IR MAR is \$500.00.
2. Respondent has already reimbursed \$350.00 for CPT code 99456-WP-W5, therefore an additional \$150.00 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$150.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of \$150.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

February 27, 2012

Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.